ORDS Research Reference Center

MEDICAL INSURANCE BENEFITS

A PROGRAMMED LEARNING TEXT

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

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This booklet is designed to summarize title XVIII of the Social Security Act for the specific purpose of training Social Security Administration employees.

It does not take the place of regulations, operating procedures, or manual instructions.

Bureau of Health Insurance
Division of Management
Training Staff

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TO THE STUDENT

This is the third in a series of programmed learning texts covering the Health Insurance program. This text is limited to supplementary medical insurance provisions. Before working through this text you should complete the program on Medicare Enrollment. This text assumes the student has knowledge of certain basic material that is presented in Medicare Enrollment. It is preferred that this text be studied after you have completed the second in the series, but this is not mandatory.

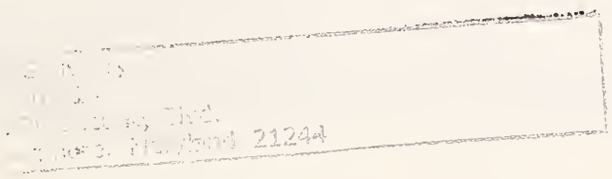
This is not an examination, but a programmed learning text. You will get maximum benefit from it by following instructions carefully:

1. When a response is called for, write it in the space provided before checking your answer. This has the effect of forcing you to make a decision, and helps fix the correct answer in your memory.

2. If you choose an incorrect response, reread the frame or frames teaching that concept.

3. Proceed at your own best speed for reading and comprehension. Don't worry about how fast or slow someone else seems to be going. It is not necessary to complete this program in one session.

Most of the pages in the text require the use of an "answer mask," which is provided on the back cover if you do not already have one that is precut. Place the mask on the page so it reveals only the top frame, covering the answers at the right. After you have selected your response slide the mask down to expose the correct answer and the next frame. Proceed in this manner until you are instructed otherwise.



The Supplementary Medical Insurance (SMI) program pays for specified medical and other health services. Benefit payments under SMI are made for 80% of the reasonable cost or reasonable charge of most covered services furnished an individual, except that the program does not pay for the first $60 in covered expenses in a calendar year. The following frames are concerned with which services are covered and which are not. GO ON TO THE NEXT FRAME	
Services of physicians are covered whether these services are performed in an office, the patient's home, a hospital, or other institution. Mary Jones is examined by a physician in his office. The physician's services _____ covered. (are, are not)	are
Surgery performed by a doctor in a hospital is covered under the SMI program because it is a service performed by a _____.	physician
Services and supplies incident to services performed by physicians are also covered under SMI. Bill Harvey visits his physician, is examined, and given an injection of penicillin by the physician. The charge for the injection is also covered since it is _____ to the physician's services.	incident
Did you notice your answer should have read "incident to" and not "incidental to?" It is fairly important to recognize that there is a technical difference in using these two terms. The word incidental implies a chance occurrence or secondary importance, whereas "_____ to" indicates a necessary relationship.	incident

Services incident to the services of a physician include drugs and biologicals only if they cannot be self-administered. Whether it can be self-administered is based on the usual method of administration as furnished by the physician. If a drug or biological can be self-administered (even though incident to a physician's service), it _____ be covered. Most other services and supplies furnished by a physician are considered incident to his services. (can, cannot)	cannot
Drugs or biologicals, then, are covered only if they cannot be _____-_____ and are incident to covered physicians' services.	self-administered
As a rule, drugs are not generally covered under the supplementary plan. They may be if they are _____ to covered physicians' services and cannot be _____-_____.	incident self-administered
The term "physician" includes doctor of medicine and osteopathy, and within certain limitations, doctor of dentistry, podiatry, and optometry, and a chiropractor legally authorized to practice by a State. GO ON TO THE NEXT FRAME	
The definition of a physician under SMI includes a dentist or oral surgeon when he performs surgery related to the jaw. Dr. Amalgam, a dentist, peforms surgery to repair a broken jawbone. Since this is within the SMI definition of a _____, his services are covered under SMI.	physician

John Incisor, D.D.S. submits a bill for dental work he did on George Watson, a Part B beneficiary. The itemized bill indicates that he put in a full crown, a bridge, and repaired a partial upper plate. Will this bill be payable under Part B? Give your reasons.	No. Dr. Incisor is considered a physician only when performing surgery related to the jaw. Crowns, bridges, plates, and repairs of fractures do not involve jaw surgery.
The services of a podiatrist (or surgical chiropodist) are covered except for routine foot care, flat foot, and subluxation.* Dr. Foote's nonroutine services then _____ covered by Part B beginning in 1968. (are, are not) *Subluxation means, partial dislocation or displacement of joint surfaces, tendons, ligaments, or muscles of the foot.	are
However, only those nonroutine services which a podiatrist (or surgical chiropodist) is legally authorized to perform by State law are covered under SMI. GO ON TO NEXT FRAME	
The podiatrist's nonroutine services are covered whether they are performed in an office, the patient's home, a hospital, or institution. John is treated by a podiatrist in his office. The podiatrist's services _____ covered. (are, are not)	are
Certain services which a podiatrist renders are <u>not</u> covered. These include routine foot care such as removal of corns, warts, or calluses, trimming of nails, treatment for flat feet, and treatment of partial dislocations of the foot. Paul visits a podiatrist to have a corn removed. This expense _____ covered. (is, is not)	is not

The services of a podiatrist which are covered under SMI are the same ones which would be covered if they were performed by a medical doctor (M.D.) or osteopath (D.O.), subject to the limits on the scope of services which the podiatrist is legally authorized to perform in the State in which he is licensed. Since diagnostic services when rendered in a physician's office are covered, they _____ covered when rendered in a podiatrist's office. (are, are not)	are
In review, services related to a condition of the foot, whether furnished by a podiatrist or a medical doctor, are covered under the medical insurance program except for _____ care, flat foot, and subluxations. (Routine footcare services may be covered, if performed as a necessary and integral part of otherwise covered services, or if non-professional performance of procedures is considered a hazard to an individual.)	routine
Routine physical checkups and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses are excluded from Medicare coverage. The term "eye refraction" means to test the eyes with various lenses and procedures to determine the correct eye prescription. GO ON TO THE NEXT FRAME	
The definition of a physician under SMI also extends to optometrists but only for the purpose of attesting to a patient's need for prosthetic lenses (lenses used by persons lacking the natural lens of their eyes). The optometrist must be legally authorized by the State to practice optometry. TO ON TO THE NEXT FRAME	
Dr. Seckler, a licensed optometrist, after examining Al Kornea, a Part B beneficiary, determined he needed prosthetic lenses and therefore prescribed them for him. The prosthetic lenses _____ covered. (are, are not)	are

Dr. Seckler in this case is considered a _____ under Medicare because he _____ _____.	physician attested to the need for the prosthetic lenses.
Are the eye refractive services employed by Dr. Seckler in determining Mr. Korenea's need for prosthetic lenses covered by Medicare? _____ (yes, no)	no, refractive services are not covered under Part A or Part B
For review then, an optometrist may only be considered a physician for the purpose of attesting to a patient's need for prosthetic lenses. Only the reasonable charge for the lenses will be covered but not the _____ _____ _____ rendered in determining the need.	eye refractive service
Let us review what we have learned so far. We have learned that the Part A program protects against the cost of hospital and related services while the SMI program protects against the cost of _____ services and other medical costs.	physician's
Hospital Insurance is automatic for almost everyone over 65 while coverage under SMI is _____. A person age 65 is automatically enrolled for supplementary Medical Insurance if he is a _____ or _____ beneficiary. Also, a disabled beneficiary is _____ enrolled in the SMI program beginning with the 25th consecutive month of disability entitlement.	voluntary social security RRB automatically

Diagnostic laboratory tests performed in an independent clinical laboratory are covered if the laboratory is properly licensed or approved as meeting standards by the State or local agency responsible for licensing, provided the HEW standards are also met. Even though a laboratory is licensed and approved by the State, it must also meet _____ provided by HEW regulations.	standards
Allbright Laboratories, Inc., is not licensed or approved by a State or local agency to perform diagnostic tests. In Allbright's State, there is no provision for licensing by State or local agencies. In this situation Allbright may participate since there is no licensing or approving agency, but they must, however, be certified as meeting HEW's _____ as provided in regulations.	standards
When there is no State or local provision for control of diagnostic laboratories, they do not have to meet the requirement that they be licensed or _____.	approved
An independent clinical diagnostic laboratory must always, however, meet the _____ provided in HEW regulations.	standards
Diagnostic laboratory services performed in a physician's office are always covered. For diagnostic laboratory services performed outside a physician's office or hospital to be covered, the laboratory must be _____ or approved in States having such provisions, and meet the _____ provided in HEW regulations.	licensed standards

Mr. B who recently had abdominal surgery is being released from the hospital to recuperate at home. Though he lives only eight blocks from the hospital, his surgeon ordered an ambulance to take him there. This service _____ covered. (is, is not)	is, but only if other means threatened re-injury or endangered the patient's health
Payment may be made for purchase of durable equipment if the beneficiary decides to purchase. Bill needs an oxygen tent and wants to purchase it. We _____ pay for its purchase. (could, could not) The controlling factor for deciding whether durable medical equipment will be rented or purchased is the preference of the beneficiary.	could
Radiological therapy is also a service provided under SMI. These include X-ray, radium, and radioactive isotope therapy. Bill Smith received cobalt treatments. These treatments are covered because this is a type of _____therapy.	radiological or radioactive isotope
Surgical dressings, splints, casts, and other devices for the reduction of fractures and dislocations are covered. Also, the purchase or rental of durable medical equipment (iron lungs, wheelchairs, and similar equipment) is covered. Additionally, braces, artificial limbs, and artificial eyes are covered. Ambulance services are covered, when other means of transportation would endanger the patient's health. GO ON TO NEXT FRAME	
William Bird elects to use ambulance service to be admitted to a hospital because his son cannot get the day off to drive him there. He is able to get around well, and riding in an automobile is no problem for him. This would not be covered since other means of transportation would not _____ Mr. Bird's health.	endanger

Dr. Ama tells Mrs. Smith that he will order an ambulance to take her to the hospital. He tells her she must remain in a reclining position until a complete examination is made. Since this ambulance service appears to be necessary, it probably _____ (would, would not) be covered under SMI.	would
Sam needs an iron lung and arranges for the purchase of the lung on a long term installment contract. The monthly payments are the same as rental charges. SMI _____ (would, would not) pay benefits on the purchase price in monthly payments in an amount equal to the reasonable monthly rental charge.	would
SMI will make periodic payments for durable medical equipment only for the period of time the equipment is determined to be medically necessary. In case of the patient's death, payments would _____ since the equipment is no longer medically necessary.	stop
Payment for inexpensive equipment ($50 or less) will usually be made in a lump sum when it is less costly or more practical to do so. Jose was badly burned, and needs a special hospital bed, although he is convalescing at home. The bed costs $350. SMI will pay for it in _____ (a lump sum, installments).	installments
Rosco needs a walker, costing $49.55. It rents for $15 monthly. He decides to buy it, since his broken hip may not heal enough for him to walk in 4 months. What method of reimbursement will be used?	lump sum

In addition to medical and other health services, certain home health services are also covered. Up to 100 home health visits per calendar year are covered under SMI in addition to the 100 home health visits covered under the _____ program. Effective 1/1/73, SMI covers 100% of the "reasonable costs" of home health services, after the deductible has been met.	(Part A or hospital insurance)
The 100 home health visits under SMI (Part B) are not related to a previous stay in a hospital or skilled nursing facility as in Part A. The _____ visits (how many) in the supplementary plan are counted during a calendar year.	100
Unlike the Part A program, the 100 home health visits provided in the supplementary plan are within a _____ year.	calendar
In addition to the above requirements, to receive covered home health services, under Part B, a physician must establish a plan of treatment and certify that the person is confined to home in need of intermittent skilled nursing care, or physical or speech therapy. Henry is receiving skilled nursing care from a participating home health agency. He has never been to a hospital and has not had a physician's care because he says that he does not believe in doctors. The Welfare Department arranged for the home health services. These services are covered. (True or False)	False
The medical services covered under home health care are the same under both the HI and the SMI program. The differences then are that under the SMI program: 1. No prior stay in _____ or _____ is required. 2. The 100 visits are within _____.	hospital, SNF a calendar year

We said that Part B pays for specified medical and other health services. Outpatient hospital services are included in this category. Outpatient services include diagnostic tests such as diagnostic X-rays, pulmonary function tests, and urinalysis. Also included are outpatient therapeutic services such as setting broken bones and applying plaster casts, minor surgery not requiring overnight hospitalization, and treatment of burns, cuts, and abrasions. GO ON TO NEXT FRAME	
All outpatient services are included in Part B coverage. Therefore, a pulmonary function test performed for beneficiary, Kole Miner, in May 1968 at the Appalachian Hospital outpatient clinic is covered under _____.	Part B (or SMI)
John has an X-ray for a suspected fracture at the City Hospital outpatient service. This is covered under _____.	Part B (or SMI)
Outpatient services are covered when rendered by a non-participating hospital if they are emergency services and would have been covered had the hospital been a participating provider of services, and if the hospital meets certain minimum requirements. GO ON TO NEXT FRAME	
Morgan had his tonsils removed at the Plush Hospital outpatient clinic. This was not due to an emergency and the hospital is not participating in Medicare. The hospital service is _____, although his physician's charge for the operation would be covered.	(not covered or excluded)

Outpatient physical therapy services are covered if furnished by or under arrangements by a participating provider of services. GO ON TO NEXT FRAME	
Outpatient _____ _____ services may also be provided by other parties under arrangements with and under the supervision of providers of services.	physical therapy
The term _____ _____ _____, for the purpose of outpatient physical therapy, includes participating clinics, rehabilitation agencies, and public health agencies, as well as, hospitals, skilled nursing facilities, and home health agencies.	provider of services
Outpatient physical therapy treatment rendered by providers of services may be furnished on the provider's premises, in the beneficiary's home, or in another health care institution. GO ON TO NEXT FRAME	
The physical therapy must be conducted according to a written plan established and reviewed periodically by a physician. The plan must prescribe the type, the amount, and duration of physical therapy services to be furnished. GO TO NEXT PAGE	

Jim Fischer recently begain a restorative program of physical therapy prescribed by his physician, William White, M.D. Jim receives his treatment as an outpatient at Community Hospital, a provider of services. In developing Jim's therapy, Dr. White specified the need for the services and specified the type and amount of treatment. Jim can expect that his planned outpatient physical therapy program _____ be covered by SMI. (will, will not)	will not. Dr. White failed to indicate the expected duration of physical therapy services.
Outpatient physical therapy is normally a covered service as long as the therapist has the required affiliation with Medicare, and there is a plan drawn up by a physician which prescribes the _____, an _____, and the _____ of required treatment, and also provides for periodic physician review.	type, amount, duration
However, outpatient physical therapy services of a qualified independently practicing therapist, if otherwise covered, must be rendered either in his office or in the beneficiary's home. GO ON TO NEXT FRAME	
A physical therapist in independent practice would have to meet licensing and other prescribed standards (health and safety requirements) in order to have his service _____.	covered
Services of a qualified physical therapist in independent practice are covered under the label of "outpatient physical therapy benefits." GO ON TO NEXT PAGE	

Reimbursement for the services of a physical therapist in independent practice are limited to $100 of incurred expenses per calendar year. GO ON TO NEXT FRAME	
Jill Loper was confined to bed for two months in 1973 as a result of a serious fall. During this period Jill received physical therapy services at home from a qualified physical therapist, practicing independently. The therapist charged Jill $150. Assuming that Jill's services were covered and that she had already met her $60 deductible, Jill could expect SMI to pay $_____ (how much) of her physical therapy expenses.	$80. (80% of $100 maximum incurred expenses in each calendar year)
Certain medical and other health services (diagnostic tests, prosthetic devices, braces, drugs which cannot be self-administered, X-ray therapy, physical therapy, etc.)that are ordinarily covered under Part A are covered by Part B if the services were rendered to an inpatient in a qualified hospital or skilled nursing facility and the patient has exhausted his eligibility, or is not otherwise eligible for Part A coverage. GO ON TO NEXT FRAME	
For these certain medical and other health services to be covered under Part B, they must be services which are normally covered under _____ when furnished by a participating provider of services.	(Part A or hospital insurance)
Thus, if George Adams has used all his available days of hospital care under Part A and continued to be hospitalized, requiring a continuing series of X-rays and laboratory tests taken by the provider every week, there would be reimbursement under Part B for the X-ray services and laboratory services, because _____ had run out.	Part A

However, if Jane Morehead has used all her Part A coverage but requires some X-rays while still in the hospital, this service will be covered under _____ if she is enrolled.	Part B (or SMI)
Radiology and pathology services, rendered by physicians in the field of radiology and pathology respectively, are covered under SMI, even when performed for inpatients. SMI provides for payment of full reasonable charges for such radiology and pathological services rendered to hospital inpatients. The SMI deductible and coinsurance _____ apply to radiological or pathological services rendered by physicians in these specialities to hospital inpatients. (do, do not)	do not
SMI provides for payment for diagnostic X-rays taken in the patient's home or in a nursing home, if they are taken under the general supervision of a physician and if they meet health and safety regulations. GO ON TO NEXT FRAME	
Portable X-rays are covered under SMI if they are taken under the general supervision of a _____ and meet health and safety regulations.	physician
The equipment used and the X-ray equipment operator's competency must meet _____ and _____ _____.	health, safety regulations

Reimbursement under both Part A and Part B will be made only for medically necessary covered items and services. In most instances of medical treatment, we can assume medical necessity, but a physician's certification may be required for certain services.	
Generally, for most Part B services, diagnosis and treatment for illness or injury is involved, so we can _____ medical necessity by inspecting the itemized bill.	assume
Treatment in hospital outpatient departments is always considered medically _____ without a physician's certification.	necessary
A written certification by a physician could be required in some instances for covered services performed by non-physicians but under the supervision of a physician. Normally, medical necessity for these services can be determined from the itemized bill, so you should have relatively few cases requiring physician's certification under Part _____.	B
You must be aware, however, of those instances in which a claim is made for services which are not medically necessary. For example, a physician visits his nursing home patients twice each day, although most of them are in good health and require no treatment or examination. This would be an example of services which are not _____ _____.	medically necessary

Public confidence in Medicare is directly related to the integrity of the program. All employees of the administration and of the intermediaries and carriers share a joint responsibility for early detection and referral of fraud and program abuse. The degree of confidence shown in the Medicare program is directly related to its _____.	integrity
There is a difference between fraud and program abuse. Fraud is a criminal violation of the Social Security Act, which upon conviction can result in fine or imprisonment. A beneficiary presents an itemized bill which has been altered to show 12 office visits instead of two and the total charged from $20 to $200. This is an example of _____.	fraud
Any false statement or misrepresentation of material facts for use in determining a right to payment or the amount of payment is punishable by law. This is the definition of _____.	fraud
Cases involving either fraud or program abuse should be referred to the Regional Office of the Bureau of Health Insurance (HIRO). The Program Integrity staff in HIRO is responsible for the development of all suspected violations and abuses involving medicare benefits. GO ON TO NEXT FRAME	
You suspect that a clinic is charging twice (the beneficiary and Medicare) for the same service. You should do which one of the following? a. contact the clinic to make sure b. refer the matter in writing to HIRO	b

For most services covered by SMI, the individual will share part of the cost of the covered services. Under SMI the individual must pay _____of the cost.	part
The supplementary plan pays 80% of reasonable charges after the first $60 during a calendar year. The first $60 is called the deductible. After the deductible has been met, SMI pays 80% of the _____ _____. (NOTE: Payment is 100% of reasonable costs for home health services and 100% of reasonable charges for certain radiology services).	reasonable charges
Incurred expenses are defined as being any medical expenses which would ordinarily be covered by the SMI program. Harry visits his doctor for treatment of a bronchial infection. This _____ an incurred expense. (is, is not)	is
Sophie visits Dr. Gleason every 6 months for a periodic routine physical examination. This type of service is not covered by SMI and would not be an _____ expense.	incurred
The date the service is rendered determines whether or not it is covered rather than the date the bill for the services is received. GO ON TO NEXT PAGE	

Any expense for medical services received before the enrollee's coverage under SMI is not an incurred expense. Carmen, age 65 in October 1973, enrolled for the SMI program in November 1973. Since her coverage under the program begins 1/1/74 any medical expense for service received before _____is not an incurred expense.	1/1/74
Similarly, Jules enrolled in June 1973. He attains age 65 in August 1973. Any expense for services received before _____cannot be counted as incurred expense.	8/1/73
The enrollee is responsible for the first _____ of reasonable charges.	$60
After the first $60 of these expenses, SMI will pay _____percent. (Except, payment is 100% of reasonable costs for home health service and 100% of reasonable charges for certain radiology services)	80
In figuring the $60 deductible you count only the expense incurred between January 1 and December 31. For those persons whose coverage begins after January 1 of a year, incurred expenses _____ include any expense for services received before the month of first entitlement. (can, cannot)	cannot

Therefore, for persons whose coverage under SMI began July 1, 1973, incurred expenses are counted starting July 1, 1973, and ending _____.	12/31/73
If the incurred expenses for services are $60 or less in a year, then any expenses incurred in the last 3 months of that year can be carried over and applied toward the deductible in the following year. GO ON TO NEXT FRAME	
For example, Carmella's coverage under the SMI program began in July 1973. Her only incurred expenses in 1973 was $20 for physician's services in October. Carmella _____ count the $20 toward meeting the deductible in 1974. (may, may not)	may
If Carmella's incurred expenses were $15 from July through September 1973, and $30 from October through December 31, she could then count $_____ toward meeting the $60 deductible in 1974.	$30
Also, if incurred expenses do not go over $60 until the last 3 months of a year, then any expenses in the last 3 months used to meet the deductible in that year can also be used to meet the $60 deductible for the next year. For example, Gustaf had incurred expenses of $10 in September 1973, and $1,000 in October and November. The $10 incurred in September can apply only to the $60 deductible for 1973, but the first $50 incurred in October may apply both to the 1973 and 1974 deductibles. GO ON TO NEXT PAGE	

George is enrolled in the SMI program and his coverage begins in January 1973. From January 1 through September 30, his incurred expense for medical services amounts to $40. In the last 3 months, they amount to $457. Since $20 of the incurred expense was used in the last 3 months (Oct., Nov., Dec.) to meet the $60 deductible for 1973, the $_____ can be counted toward meeting the $60 deductible in 1974.

$20

If George's incurred expenses were $60 in the period January 1 through September 30, none of the incurred expenses ($457) in October, November, December could be used in meeting the $_____ deductible in 1974.

$60

If none of the incurred expenses in the last _____ months of the year were used in meeting the deductible for that year, none can be carried over and applied toward the deductible in the following _____.

3

year

Assuming SMI coverage for the full year, show the amount of the incurred expense in 1973 used toward meeting the deductible in 1974.

INCURRED EXPENSE 1973		1974 CARRYOVER
Jan. - Sept.	Oct., Nov., Dec.	
$150.00	$ 65.00	None
40.00	90.00	$20.00
10.00	30.00	30.00
60.00	15.00	None
-. -	150.00	60.00

SMI benefit payments are made regardless of whether the beneficiary actually pays his share of the charges. This insures that whoever furnishes covered medical services will at least get the SMI payment quickly, even though the beneficiary may be slow in paying his share. In any event, the amount owed by the beneficiary is based on reasonable _____.

charges

After the deductible, the SMI program pays 80 percent of the reasonable cost for Part B services provided by participating hospitals, skilled nursing facilities, and home health agencies. These organizations are called providers of services. Payments for services furnished by providers of services are based on reasonable cost. The reasonable cost of a particular service is computed at the end of the provider's accounting year, when the provider settles its account with SSA. GO ON TO NEXT FRAME	
Part B payments made to providers of services are based on _____ _____. (There are some exceptions, which we will discuss later.)	reasonable cost
All Part B payments, other than those based on reasonable cost, are made on the basis of reasonable charges. Determinations as to what is a reasonable charge is made for a service in a particular area. For example, payment for a physician's service is based on reasonable _____.	charges
We have learned that when Part B services are furnished by a provider, the SMI payment will be 80 percent of _____ _____, after deducting any unmet portion of the deductible.	reasonable cost
Before we start the next section, let's review the way payments are made for Part B services. When a provider of services furnishes the Part B service, the payment is 80% of reasonable cost, after the deductible is met. Providers must agree not to charge the patient more than 20% of the _____ _____ for covered services.	reasonable charge

When a physician or supplier of covered goods or services accepts an "assignment" under Part B, he agrees to accept the reasonable charge as full payment. After the deductible, the beneficiary is responsible for paying _____ percent of the remaining reasonable charge to the physician or supplier who has accepted assignment.	20
We have just reviewed the two instances when a beneficiary's responsibility for payment is limited to 20 percent of the reasonable charge (after the deductible). This limitation applies when services are furnished by: 1. A _____ of services. 2. A _____ accepting assignment.	provider physician
In situations where the physician or supplier of services does not agree to accept assignment and the beneficiary applies for reimbursement, the SMI program will still pay 80 percent of the reasonable charge above any unmet deductible, but there is no Medicare limitation on what the physician or supplier can charge the patient. GO ON TO NEXT FRAME	
A Part B "carrier" is an organization which has entered into an agreement with SSA to perform specified administrative functions under the medical insurance program. One of these functions is determining the amount of the reasonable charges and making payment to beneficiaries and/or physicians, suppliers, and others who furnish Part B services and supplies. GO ON TO NEXT FRAME	
CONTINUE ON THE NEXT PAGE--YOU DO NOT HAVE TO USE YOUR MASK FOR THE NEXT SECTION. USE THE BLANK PORTION OF THE PAGES TO DO ANY NECESSARY FIGURING.	

ITEM 1 Under the Part A program, benefit payments are always made to the provider of services, and almost always through a fiscal intermediary. Under SMI, on the other hand, benefit payments may be made to physicians or other suppliers of covered goods and services, or the individual himself, through carriers.

The payment of benefits based on "reasonable cost" is made directly to the providers of services by the same fiscal intermediary that handles Part A claims for the particular provider. The determination of what amount constitutes "reasonable cost" for any covered service is one of the intermediary's most important functions. The concept of "reasonable cost" that the intermediary applies in making the determination is the same concept as is used under the HI program.

Benefit payments under SMI are made for 80% of the reasonable cost or reasonable charge of all covered services furnished an individual, except that the program does not pay any part of the first $60 of incurred expenses in a calendar year (subject to the 3-month carryover). This means the patient is responsible for paying the deductible, the first $60 of covered services furnished by a provider of services, (i.e., an institution or agency, such as a hospital or home health agency) with the exception of some radiological and pathological charges and is responsible for the difference between what is paid by Medicare and the charges for all other services.

Beneficiary Kay Wilson's first medical expense during 1973 was a bill for $40. This charge was made by a home health agency for services it furnished Kay. These services are covered by SMI. What amount of benefits were paid under the SMI program for these services?

a. 80% of the reasonable cost of the services. (See Item 2)

b. $32 (See Item 3)

c. Neither of the above is correct. (See Item 4)

ITEM 2 (1a) This answer would be correct only if Kay already met her $60 deductible for 1973. If she had already met the $60 deductible, benefits would be paid for 80% of the reasonable cost of the services because they were furnished by a provider of services. Since the $40 charge was Kay's first medical expense of the year, the 80% benefit payment cannot be made. Please return to Item 1 and choose another answer.

ITEM 3 (1b) Your answer is "$32." This would be correct only if (1) Kay had already met her $60 annual deductible for 1973, and (2) $40 was the reasonable cost of the services Kay received. Payment would have to be based on reasonable cost because Kay received the services from a provider of services. Please return to Item 1 and choose another answer.

ITEM 4 (1c) Correct. Actually no benefit payments can be made now because Kay has not yet met her $60 deductible for 1973. Since the $40 charge was for covered services, however, Kay's deductible has now been partially met. As soon as she incurs $20 more for covered services during the year benefit payments under SMI can begin.

ITEM 5 Medicare beneficiary, Harry Shaffer has been furnished covered services in a physician's office. The reasonable charge for these services is $400. His physician sends him a bill for $435, which Harry pays. Assuming that Harry paid the $60 annual deductible previously, which of the following is true?

a. Harry will receive $320 from the carrier. (See Item 6)
b. Harry will receive $328 from the carrier. (See Item 7)

ITEM 6 (5a) Very good! The carrier pays Mr. Shaffer because he filed a claim for payment. He is paid 80% of the reasonable charge. Mr. Shaffer is responsible for the difference between what is paid by the program and the bill. In this case, the difference is $115. Go to item 8.

ITEM 7 (5b) You computed the amount Harry would have received had $435 been considered the reasonable charge. However, $435 is what Harry is charged by his doctor. Although he will owe this bill, he will be reimbursed only on the basis of 80% of reasonable charges. Please review Item 1 and study the explanation to the correct answer found in Item 5.

ITEM 8 Payments for physicians' services can be made either to the patient or to the person who furnishes the services. If the patient is to receive the benefit payment, he obtains an itemized bill either paid or unpaid from the doctor. The patient then presents the bill to the carrier, and is reimbursed for 80% of the reasonable charges submitted. Again the carrier is responsible for determining what amount constitutes reasonable charge.

Medical beneficiary, Sally Thorn receives covered services from her physician. Even though the carrier determined that the reasonable charge for the services Sally received was $50, her physician charged her $60. Sally paid the full $60 to her physician. Assuming that Sally already met the annual deductible for SMI benefits, which of the following statements will be true?

a. The carrier will pay Sally $40. (See Item 9)
b. The carrier will pay Sally $48. (See Item 10)
c. The carrier will pay Sally's doctor $40, and the doctor will refund $20 to Sally. (See Item 11)

ITEM 9 (8a) Your answer is correct. Sally's carrier will pay her $40 which is 80% of the reasonable charge for the services she received. The carrier always reimburses the patient for 80% of the reasonable charge for covered services, either when the patient pays the physician and receives a receipted bill, or when the patient who has not paid the physician submits an itemized bill to the carrier. Now go on to Item 12.

ITEM 10 (8b) Since Sally submitted the physician's bill to the carrier herself, the carrier will make the benefit payments to Sally directly. However, the carrier will only pay for 80% of the reasonable charge for the services furnished by the physician. $48 is 80% of $60, the amount the physician actually charged. Return to Item 8 and choose another answer.

ITEM 11 (8c) Although the carrier will only pay 80% of the reasonable charge for services rendered by a physician, the payment of this benefit is made directly to the patient if the patient presents the itemized bill for the services. Please return to Item 8 and choose another answer.

ITEM 12 If the physician and patient agree, the patient may assign the benefit payment to the physician. This means that the carrier will make the benefit payment directly to the physician. Under an assignment, the physician agrees to accept the reasonable charge as full charge for the services rendered.

Going back to our previous example, let's assume that Sally assigned the payment of the benefit to her physician. Remember, the physician's charge for the services was $60, and the reasonable charge as determined by the carrier, was $50. Which of the following statements is true.

a. The carrier will pay Sally's physician $50 and Sally will owe him nothing. (See Item 13)

b. The carrier will pay Sally's physician $40 and Sally will owe him nothing. (See Item 14)

c. The carrier will pay Sally's physician $40 and Sally will pay him $10. (See Item 15)

d. The carrier will pay Sally's physician $40 and Sally will pay him $20. (See Item 16)

ITEM 13 (12a) You say the carrier will pay Sally's physician $50. Let's think about this for a moment. The carrier has determined that $50 is reasonable charge of the doctor's services. We also know that under an assignment of benefits the physician must accept the reasonable charge as full charge. However, benefit payments by a carrier direct to a personal physician are never the full reasonable charge for covered services, but are only 80% of that amount (after the deductible). Now return to Item 12 and choose another answer.

ITEM 14 (12b) You have correctly determined that the carrier will pay Sally's doctor $40, which is 80% of the reasonable charge for the covered services. However, the doctor is entitled to the full amount of the reasonable charge under an assignment. Please return to Item 12 and choose another answer.

ITEM 15 (12c) Good work! Under an assignment of benefits, the physician agrees not to accept more than the reasonable charge for his services. The carrier has determined that the reasonable charge for the services Sally received from her physician is $50. The carrier will pay the doctor 80% of the reasonable charge, or $40, and Sally is responsible for the remaining 20% of such reasonable charge, which is $10. Now go to Item 17.

ITEM 16 (12d) You are partially correct. The carrier will pay Sally's physician $40, which is 80% of the reasonable charge for the services she received. If Sally also pays the doctor $20, then he will have received $60, the full amount of his usual charge. Under an assignment, however, the physician must agree not to take more than the reasonable charge for his services. Now return to Item 12 and choose another answer.

ITEM 17 The $60 deductible and 80% benefit computation rule apply, in general, to all services furnished under SMI during each calendar year. However, with respect to the treatment of mental, psychoneurotic, or personality disorders of an individual who is not a hospital inpatient, only $312.50, or 62 1/2% (whichever is smaller) of the expenses for physician services rendered in connection with such treatment can be counted as incurred expenses to which the $60 deductible and 80% rule apply.

Beneficiary Roger Dormant's first medical expense this year is for psychoanalytic treatment he receives from Dr. Westwood. The reasonable charge for these treatments is $300. What amount of benefits will be paid under SMI for these services? Roger is not a hospital inpatient. There is no deductible carry over from last year.

a. $150 (See Item 18)
b. $102 (See Item 19)
c. $120 (See Item 20)

ITEM 18 (17a) Your answer is "$150." This would be correct only if Roger had already met his $60 deductible for the year. Since these services were the first covered medical services Roger received during the year, he must pay the $60 deductible before benefit payments can be made. Please return to Item 17 and choose another answer.

ITEM 19 (17b) Excellent! $102 is correct. Since the psychiatric services Roger received were not furnished to him as a hospital inpatient, only 62 1/2% of the expenses incurred for physicians' services in connection with his treatment of a psychiatric condition can be considered covered by the SMI program. The amount of benefits payable is computed as follows:

62 1/2% of $300 = $187.50

$187.50 less $60 annual deductible = $127.50

80% of $127.50 = $102

ITEM 20 (17c) Your answer is $120. In arriving at this answer you remembered to account for both the $60 deductible and you applied the 62 1/2% limitation. However, you began by reducing the $300 by the $60 deductible, whereas you should have <u>first</u> taken 62 1/2% of $300, and then accounted for the deductible. Return to Item 17 and choose another answer.

GO ON TO THE NEXT PAGE AND USE THE MASK AGAIN

The form SSA-1490, Request for Payment, may be completed and sent to the carrier as soon as expenses for covered services are incurred under SMI. However, no payment can be made until after the enrollee has satisfied the $_____ deductible.	$60
June Smith completes an SSA-1490 and submits 6 itemized bills from Dr. Craft totaling $120. The carrier determines the reasonable charge to be $100. Assuming this is Jane's first claim this year, she will be reimbursed $_____.	$32
Under the assignment method of reimbursement, the enrollee completes Part I of the SSA-1490. If the physician or other supplier of covered services agrees to the assignment, he will complete Part II of the form and send it to the carrier. To use the assignment method then, the physician or other supplier of covered services must _____ to the assignment in writing.	agree
Where assignment is agreed to, the reimbursement is made to the doctor or other supplier of services on a "_____charge basis."	reasonable
Under the assignment method, the doctor or other supplier of services must accept the reasonable charge determined by the _____as his total fee for covered services.	carrier

Dr. Smith submits an SSA-1490 for services rendered to Mary Katz in the amount of $150. The carrier determines the reasonable charge for these services to be $100. Dr. Smith must accept this determination. Assuming the $60 deductible is met, Dr. Smith may not bill Mary for more than $_____. (20% of the reasonable charge).	20
Dr. Smith will receive $_____ from the carrier on assignment.	80
Where the assignment method is used, the doctor or other suppliers of services must accept the reasonable _____ as determined by the _____.	charges carrier
The two methods for claiming reimbursement under the SMI program are by _____to the physician or payment to the _____.	assignment patient (enrollee)
The Request for Payment Form is the SSA _____.	1490

Underpayments for medical insurance benefits due a deceased beneficiary are taken care of in two ways, depending on whether the bill was paid or unpaid. Payment can be made to the physician (or other supplier of services) for unpaid bills if he agrees to accept the reasonable charge for the service as his full charge. Thus, underpayments can be paid direct to the _____ in the case of unpaid medical bills.	physician
Jackson Andress, who had already met the $60 SMI deductible was under the care of Dr. Jones when he died. Dr. Jones had performed covered services for which his fees total $325. The reasonable charge for these services is established as $287. Since the bill is unpaid, Dr. Jones can claim reimbursement for $_____, if he accepts $287 as his full charge.	$229.60 (80% of $287)
If the medical bill has been paid, the law sets up a standard list of priority for the SMI underpayment: 1. Payment to the person who paid the bill. 2. Payment to the legal representative of the beneficiary's estate. 3. Payment to relatives of the beneficiary in the order of priority provided for monthly cash benefit underpayments. GO ON TO NEXT FRAME	
The first person to whom SMI underpayments will be made if the medical bill has been paid is _____ _____ _____ _____ _____.	the person who paid the bill
If there is no possible payment to a person who paid the bill because the beneficiary paid the bill, next in priority is the _____ _____ _____ _____ _____.	legal representative of the beneficiary's estate

If there could be no payment to the person who paid the bill, or if the beneficiary paid the bill, and there is no legal representative of his estate, the underpayment may be paid in accordance with the priorities established for making _____ _____ underpayments.	cash benefit
To review, underpayments for : 1. Unpaid bills may be paid to the _____. . .	physician
. . . if he agrees to accept the _____ charge as his full charge.	reasonable
Underpayments for: 2. Paid bills must be made in this priority: a. To the _____ who _____ the bills, or . . .	person, paid
b. . . . if paid by the beneficiary or with funds from his estate, to the _____ _____ of the beneficiary's _____, or . . .	legal representative estate

c. . . . if there is no legal representative, to persons in the order of priority established for _____ _____.	cash benefits
A claimant who is denied supplementary medical insurance (Part B) benefits because of an entitlement factor may appeal in the usual manner. The appeals process is identical with that followed in our usual RSDI cases where the issue is _____ to SMI.	entitlement
The Part B appeals process is identical to that followed in RSDI cases when the claimant for SMIB is denied benefits because of a factor of _____.	entitlement
Where, instead of entitlement, the issue involves the coverage of the service or amount of benefits payable, the claimant's recourse depends on whether the benefits are payable under HI or SMI. GO ON TO NEXT FRAME	
This does not mean that the district office will divorce itself from disagreements arising under the SMI program. For example, a misunderstanding of deductibles of other program areas, may, if clarified, satisfy the inquiry. There will also be cases where assistance should be given the claimant in requesting a review of a decision by the _____.	carrier

We learned that disagreements in entitlement and money matters under hospital insurance are dealt with by _____ under an appeals, process, while . . .	SSA
. . . . under the SMI program, only _____ factors are handled within the usual SSA appeals process.	entitlement
YOU NOW HAVE A BASIC KNOWLEDGE OF SUPPLEMENTARY MEDICAL INSURANCE. EXPERIENCE ON THE JOB AND FREQUENT USE OF YOUR OPERATING MANUAL WILL COMPLETE YOUR TRAINING.	

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